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January 23, 2013

TO: Each Supervisor

FROM: Mitchell H. Katz, M.D.  
Director

Tobi L. Moree  
Chief Compliance Officer

SUBJECT: **DEPARTMENT OF HEALTH SERVICES  
COMPLIANCE PROGRAM: STATUS REPORT**

Mitchell H. Katz, M.D.  
Director

Hal F. Yee, Jr., M.D., Ph.D.  
Chief Medical Officer

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Strategic Planning Deputy Director

The goal of the Department of Health Services (DHS) Compliance Program is to ensure that DHS and its workforce members comply with applicable laws, regulations, policies and other standards of conduct. The primary focus of the Compliance Program is adherence to government and private health plan requirements and on laws that govern health care business practices, such as the False Claims Act, fraud and abuse laws, and privacy laws.

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Following is a summary of significant Compliance Program activities and events since the last status report of December 29, 2011.

Recovery Audit Program

In 2009, the Centers for Medicare and Medicaid Services (CMS) implemented the national Recovery Audit Program (previously known as RAC). The purpose of the Recovery Audit Program is to identify improper Medicare payments. CMS contracts with private Recovery Auditors to conduct post-payment reviews through automated analysis of claims and/or by reviewing medical record documentation. Health Data Insights, Inc. (HDI) is the Recovery Auditor in California.

Recovery auditors use two review processes to perform their claims analysis: automated and complex review. Automated reviews are performed when there is an evident payment error and complex reviews are performed on claims that have a high likelihood of errors.

Of the automated reviews, approximately 49% of accounts denied by the RAC were considered medically unnecessary, 22% were

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considered incorrectly coded, and there was either insufficient documentation or records not found for 27% of accounts.

For the year of 2012, according to the DHS Recovery Audit Contractor (RAC) Summary of Denial/Recoupment Report of November 2012, HDI requested to complex review 1179 accounts. Of these reviews, HDI closed 396 cases (about 34%) with no findings and denied 244 accounts (about 21%). It is important to note that HDI selects for complex review those DRGs/diagnoses that have a high propensity for error; therefore, this cannot be considered an average error rate at the DHS facilities. HDI identified \$1,834,926.95 in payments returned to the Fiscal Intermediary/Medicare Administrative Contractor (FI/MAC) after complex review.

Recovery Audit teams at each DHS hospital managed the Recovery Audits and took corrective actions, as needed, to ensure compliance with Medicare regulations and avoid future improper claims. The Compliance Program oversaw Recovery Audit activity and coordinated periodic DHS-wide meetings and education to discuss common issues and identify solutions/corrective actions.

#### Compliance Investigations and Audits

The Compliance Program developed its FY 2011-2012 Compliance Audit Plan based on evaluated potential risk areas and input from the DHS Compliance Committee. The FY 2011-2012 Compliance Audit Plan focused primarily on Medicare admissions reviews, privacy compliance reviews, the Compliance Update Training, and allocated resources to investigate issues raised by hotline calls and referrals from management.

During FY 2011-2012, the Audit and Compliance Division (A&CD) completed 33 compliance-related investigations and audits related to conflict of interest, billing, contract/policy compliance, falsification of documents, HIPAA/confidentiality, quality of care, and theft. Nine of these reviews identified non-compliance with policies, procedures, regulations or other standards and resulted in recommendations for corrective actions, including discipline, additional training, improved policies and procedures, revised billings and strengthened internal controls.

#### Medicare Admissions Review

This year, the A&CD completed a compliance review at Rancho Los Amigos National Rehabilitation Center (RLANRC), under the direction of County Counsel, to ensure that only medically necessary admissions are billed to Medicare. A&CD randomly selected a probe sample of 20 Medicare admissions from the period July 1, 2010 to June 30, 2011 with lengths of stay from one to four days and found that only those admissions that were deemed medically necessary (14 admissions) were billed to Medicare. The remaining six admissions were determined to not meet admission criteria and were not billed, as appropriate. The results of our review indicate that RLANRC has effective procedures in place to ensure that only medically necessary admissions are billed to Medicare.



### Patient Privacy

The State and federal laws both require the reporting of certain alleged privacy violations. For the period of December 2011 through November 2012, DHS hospitals investigated 72 alleged privacy violations and reported 28 (39%) to the State Licensing and Certification Division. The State completed an investigation of nine (33%) of the 28 reported violations and 18 are pending investigation. Three (33%) of the nine investigations conducted by the State resulted in citations against the hospital; however, to date, none of the citations have resulted in a fine. One privacy violation also met the federal reporting requirements, and was appropriately disclosed under federal law.

### Compliance Update Training

In June of 2012, the Compliance Program began implementing its Compliance Update Training, a 50-minute refresher course on Compliance meant to provide information on privacy and confidentiality of patient health information. The key concepts of the training include safeguarding patient information in all forms, accessing patient information only if there is a business need, and reporting suspected privacy breaches immediately upon discovery. All existing workforce members are required to take the training. So far, approximately 63% of workforce members have taken the training. The Compliance Program is working with the DHS Human Resources department to ensure that all workforce members are familiar with applicable laws, regulations, and standards, particularly with regard to privacy.

### Ongoing Compliance Activities

In response to the federal audit program of 2012, the DHS facilities were instructed to ensure that their internal privacy and security audits were documented and appropriate corrective actions were taken. The County HIPAA Privacy Officer conducted compliance reviews of the DHS facilities to ensure compliance with federal requirements, and DHS continued to work with the County's HIPAA Privacy Officer and Information Security Officer to implement policies and infrastructure to comply with HIPAA requirements.

Additionally, DHS management continued to provide patient privacy compliance education on various topics such as preventing privacy or security violations, reporting requirements, and safeguarding electronic protected health information. DHS revised its privacy breach reporting policy, which reminds staff of their responsibility to report any suspected privacy breaches timely.

The DHS Compliance Committee met (and continues to meet) approximately every other month to discuss and determine actions needed related to potential risk areas, new compliance initiatives/regulations, compliance training, compliance goals and priorities, policy changes, the status of compliance audits and investigations, and other compliance issues.

The Audit and Compliance Division managed (and continues to manage) the DHS Compliance Hotline. During 2012, A&CD received 50 calls through the Compliance Hotline and initiated actions to respond to these concerns, as appropriate. Twenty calls were deemed relevant to A&CD and resulted in investigations. Five of these investigations closed and two are completed and awaiting approval. Two calls had insufficient information provided in order to investigate. Fifteen calls were considered relevant to compliance but not to A&CD, and were delegated accordingly to the CBO, CEOP, Employee Relations, Risk Management, or the appropriate facility. One caller had a question regarding the Code of Ethics. Thirteen calls were deemed immaterial to A&CD.

#### Conclusion

The Compliance Program continues to focus its efforts on the primary objective of preventing, detecting, and correcting inappropriate conduct. However, budget constraints continue to limit the scope of DHS' compliance activities, particularly at the facility level. The federal and State's increased compliance requirements and enforcement efforts have resulted in additional workload and have increased the need for additional compliance resources at the facility level. This need will be assessed during 2013.

The Compliance Program will continue to provide periodic status reports to the Board. Significant compliance issues will be brought to the Board's immediate attention, as appropriate.

MHK:TLM:bns

c: Chief Executive Officer  
County Counsel  
Executive Officer, Board of Supervisors